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Hospital investment policy in France: Pathways to efficiency and the efficiency of the pathways☆

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ABSTRACT

Objectives: This article examines the ambivalent notion of New Public Management as applied to health policy in France, by investigating the implementation of the efficiency-driven hospital investment plan, *Hôpital 2012*, conceived at national level, but implemented through regional hospital authorities (ARHs), with formal responsibility for selecting successful funding applications.
Methods: The methodology combines qualitative and quantitative analysis, in order to highlight and explain discrepancies between goals and results.
Results: Despite formal adherence to objective efficiency indicators, certain decisions were based on incomplete information and others on considerations outwith initially established criteria. Competition from the private sector was perceived as a threat to public hospitals and the public sector emerged as a major beneficiary of the investment plan. Central ministerial intervention emphasising financial and quantitative considerations led the ARHs to focus more on individual hospital performance than on wider healthcare needs.
Conclusions: Data-production became almost an end in itself, threatening to undermine the objectives it sought to pursue. Nonetheless, extended deadlines entailed by ministerial intervention were appropriated as a resource by local actors, leading to ARH decisions which deviated from the official efficiency model, but resulted in increased effectiveness, taking fuller account of local conditions.

1. Introduction

Despite its reputation for 'unreformability', in recent years the French hospital system has introduced numerous principles and practices inspired by New Public Management (NPM), representing a move away from a centrally directed, administrative approach, towards more decentralized, managerial governance [1]. Such developments may be seen as part of a general shift in French policy making, with public intervention remaining prominent, but based henceforth on a logic rooted in contractualisation, competitive project submission, evaluation and responsible action by all protagonists, rather than plans imposed from above [2]. However, as Peters [3] has argued, NPM is not a theory, still less a model, but an ideology, of which many different versions exist [4]. Consequently, specific applications may engender trends which lead in different directions [5], particularly in the French hospital system where, in contrast with the United States [6], volumes of hospital investment depend largely on national-level

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policy decisions. Research into the interplay between such tensions and the ensuing policy results is therefore crucial to a fuller understanding of NPM in action. To this end, the following discussion will analyse *Hôpital 2012*, the latest French hospital investment plan, in two regions, *Rhône-Alpes* and *Provence-Alpes-Côte-d'Azur*, in order to identify and explain the postulated discrepancies between the objectives of this national plan and its implementation at regional level.

Hôpital 2012 was launched in February 2007, building on the previous investment programme (*Hôpital 2007*), but also as a new departure. *Hôpital 2012* had three general objectives: to complete the upgrading of hospital buildings in compliance with health and safety standards; to modernise computerised hospital information systems; and to support the restructuring measures set out in the regional strategic healthcare plan (*Schéma Régional d'Organisation Sanitaire*, SROS), drawn up by each Regional Hospital Agency (*Agence Régionale de l'Hospitalisation*, ARH). However, these objectives were to be pursued within a new framework of guiding principles, namely efficiency, cost control and self-reinforcing investment through improved productivity, placing great emphasis on results [7].

Accordingly, only 50% of the 10 billion euros devoted to the plan was provided from National Health Insurance (NHI) funds, via the ministerial budget for priority healthcare initiatives undertaken for the 'general good' (*Missions d'Intérêt Général et d'Aide à la Contractualisation*, MIGAC), administered separately from the activity-based payment system for routine care (*Tarification à l'Activité*, T2A), introduced in stages since 2004 to replace the fixed, global budgets hitherto allocated by the ARHs. The remaining 50% was constituted by a preferential-rate loan from the government-supervised deposit institution, the *Caisse des Dépôts et Consignations*. Each hospital seeking funding for a project under *Hôpital 2012* must therefore include evidence in its application of its own resource-generating capacity to cover 50% of the project's costs, based on its anticipated increase in activity and T2A-derived income. Government funding for *Hôpital 2012*, as stipulated in the ministerial Circular of 15 June 2007 launching the plan, was devolved *ex ante* to regions, in a budget mainly based on demographic criteria, to be allocated by the ARHs, thereby enhancing their role and influence, which had been weakened by the introduction of the T2A.

2. Efficiency as a policy goal

Materials for this study were collected through the participation of two of the present authors, as expert advisers, in the *Hôpital 2012* allocation process with the main actors involved: the hospital policy support team attached to the Ministry of Health (*Mission Nationale d'Appui à l'Investissement Hospitalier*, MAINH) and the ARHs in *Rhône-Alpes* and *Provence-Alpes-Côte-d'Azur*.

The collection of materials was conducted using "grounded theory" methodology [8], combining quantitative and qualitative data. Analysis of qualitative data was carried out through a "naturalistic" approach, seeking to understand how actors use their experience to make decisions in complex, dynamic and real time environments [9].

Eight ARH meetings were attended in *Rhône-Alpes* and two in *Provence-Alpes-Côte-d'Azur*, which had been convened to identify all projects submitted to the ARH by public and private hospitals in the region and to establish the region's priorities and eligibility criteria. Numerous informal interviews were also carried out with CEOs from the MAINH and the two ARHs.

Investment project efficiency was evaluated through quantitative data analysis: economic and financial synthetic indicators were calculated for each hospital's written proposal. Data on public and private hospital investment [10] in each region concerned was obtained from relevant websites.

This hybrid approach was designed in order to highlight and explain the discrepancies between the goals of *Hôpital 2012* and its actual implementation by the ARHs.

The procedure for *Hôpital 2012* set a tight time frame, with the first selection phase opening in October 2007 and closing in November with the communication of the accepted projects to the MAINH. The second phase was to open on 30 April 2008 and close in October 2008. The Circular set out the technical conditions with which individual hospital projects (either public or private) must comply to be selected by the ARH, and then ratified at the national level. However, the Circular stipulated that it was the responsibility of each ARH to select the successful applications.

In interviews, MAINH officials confirmed that the chief eligibility criteria for *Hôpital 2012* were improved efficiency and compliance with the SROS, to be observed as a collective responsibility. However, as demonstrated in research into the concept of hospital performance [11], the notion of efficiency is highly equivocal among French hospital stakeholders. Consequently, the plan focused on the mobilisation of all actors concerned, from the central level, through the regional level (the ARHs, regional NHI officers, regional and departmental ministerial officials), to the local level (the hospitals themselves). This highlighted the need to construct a consensus around the criteria employed, to establish the legitimacy of the selection procedure. However, this dynamic may run counter to administrative practices which, while pursuing the same objectives regarding performance and equality of treatment, are rooted in principles of top-down control and adherence to formal rules [12].

2.1. An iterative approach in Rhône-Alpes

In *Rhône-Alpes*, an initial review of applications by ARH field officers and their partners showed that 145 building-renovation projects had been submitted and 155 for information system upgrading. These meetings considered the appropriateness of each hospital's application, in terms of its budgetary situation and its project's potential contribution to the needs of the area in which it was

situated, as outlined in the SROS. While the ministerial Circular provided for two phases in the selection process, it was decided to commit the maximum level of funding possible to phase One. The aim was to identify hospital investment needs far beyond the plan itself. At these meetings, information was shared between all members of the panel in open discussion. The implementation of *Hôpital 2012* represented a stage in a pre-established policy offering support and advice to hospitals, with which all protagonists were familiar. The Ministry saw the plan as a kind of one-shot policy. In contrast, local actors explicitly included the new plan in the history of their relationships with hospital managers and local authorities. Hence, the intrinsic quality of an application was never considered in isolation from what was known of its context by members of the selection panel. *Ceteris paribus*, a hospital supported by *Hôpital 2007* would be less likely to be supported by *Hôpital 2012*. Although efficiency imperatives figured in discussion, they were not supported with calculations. Discussions focused on exchanging ideas about the financial position of each hospital, the calibre of its director and its capacity to absorb the increased activity entailed by the investment. These observations collected during the meetings, confirm the existence of tacit knowledge [13]. Moreover, the situation of the private sector, especially in those areas where chains of private hospitals have developed a concerted strategy to corner the market in particular specialities, raised questions concerning the legitimacy of support from public funds. The overall perception was that, in the face of such competition, the public service mission must be preserved, despite (or rather because of) the abrupt decision by government that the T2A system must be applied at a rate of 100% from 2008. ARH officials perceived themselves to be in the front line of a struggle to defend public service values.

2.2. A sequential approach in Provence-Alpes-Côte-d'Azur

The *Provence-Alpes-Côte-d'Azur* ARH imposed an eligibility threshold represented by a minimum level of requested funding. This threshold, introduced to compensate for the absence of clear eligibility rules to eliminate inappropriate applications, was one million euros for local hospitals, two millions for general hospitals and private clinics and five millions for Teaching Hospitals. This was circulated to all hospitals from the outset and functioned as a self-eliminating mechanism. ARH officials estimated that without this measure, 60 further applications would have been received. In interviews, when asked about the absence of a threshold in *Rhône-Alpes*, *Provence-Alpes-Côte-d'Azur* ARH officers argued that they utilised the plan to make hospitals reveal their real investment needs. The aim of *Rhône-Alpes* ARH officers was to build a catalogue for use in other circumstances, particularly the forthcoming round of the contractualised hospital planning exercise. In contrast, *Provence-Alpes-Côte-d'Azur* ARH officers explicitly wished to avoid a deluge of applications and the concomitant risk of creating expectations which could not be satisfied. These two strategies, despite (or because of) their differences, confirm that, unlike the Ministry, both ARHs situated their action within a long-term perspective.

The predominant view in *Provence-Alpes-Côte-d'Azur* was that support must be given to medium-sized hospitals, rather than those that were too small or whose needs were too great. Hospitals unable to finance a small investment could not be supported, thereby reducing the risk of a windfall effect. However, this precluded selection of low-cost projects which may have corresponded to healthcare priorities. Whereas ARH officials in *Rhône-Alpes* regretted that tight deadlines deprived decision makers of valuable information regarding healthcare needs, a similar problem arising from the thresholds in *Provence-Alpes-Côte-d'Azur* was not discussed. During this initial stage, ARH *Provence-Alpes-Côte-d'Azur* officials refrained from intervening directly in the preparation of applications, to avoid compromising future rejection decisions. ARH advice was restricted to explanations of administrative requirements and iteration between the ARH and the hospitals was kept to a minimum.

2.3. A coup de théâtre: the impact of the second Circular

Two months after the completion deadline for local selection procedures and the communication of accepted applications to Paris, the Ministry issued a second and unexpected Circular, in order to make sure that all projects about to be accepted at the regional level fulfilled the efficiency criteria. The Circular stated that for projects involving more than 10 million euros, a further document must be completed at the beginning of 2008. This form, which included no fewer than 10 categories and 25 subcategories, retrospectively requiring the supply of complex data, conveyed an impression of distrust on the part of the Ministry towards the work carried out by the ARHs. Interviews with ARH CEOs demonstrated that they did not understand the purpose of this new exercise when the whole procedure was nearing completion. The perception that they were being subjected to central bureaucratic control was exacerbated by ministerial responses to requests for clarification: central administration officials confirmed that these forms could be used to question ARH decisions. This *coup de théâtre* resembled what Padioleau describes as a *coup d'Etat*, illustrating the French central State's compulsion to intervene in areas of devolved responsibility [14]. The power of local authorities is thereby jeopardized, generating the perception that actual decision-making power remains in the hands of the central State. The destabilising impact of the second Circular was twofold. Firstly, the information required was difficult to collect in the time available and did not always appear pertinent to the objectives. Secondly, despite the interval between the trial and the publication of the second Circular, little account had been taken of the comments from the ARHs concerned, which sought to simplify the procedure and integrate the attempts already made by the ARHs to clarify their rationale in the selection process.

In *Provence-Alpes-Côte-d'Azur*, ARH staff could not assemble the required data in the time allowed, without calling upon the services of the hospitals concerned. This technical necessity undermined the linear approach hitherto adopted by the ARH in its relations with the hospitals, with which complex exchanges of information now became

necessary. During this process, the ARH asked several hospitals to revise their projects by breaking them down into functional segments, to reduce the pressures generated by demand.

In *Rhône-Alpes*, uncertainty regarding the purpose of the exercise was exacerbated when it transpired that most of the data required was already available. Secondly, it increased scope for an 'auction effect', where the involvement of local politicians, with an interest in the sensitive issue of hospital investment, can lead to commitments of variable official status, running counter to policy choices made at the central and local levels, based on technical or economic considerations. This phenomenon was intensified by the fact that the episode of the second Circular coincided with the municipal election campaign of March 2008.[3]

3. Efficiency as rhetoric in the selection process

In *Rhône-Alpes*, 145 projects (representing 3 billion euros in total) were submitted in the building-renovation category, of which 35 were retained for further consideration. 24% of bids were therefore successful, but represented 77% of the total sum of all applications. Successful bids were therefore those involving the largest financial sums, consistent with the decision to maximise funds devoted to phase One.

The acceptance rate varied markedly between sectors, as the public sector made 49% of successful applications, as against 31% for the private, not-for-profit sector, while private, commercial hospitals submitted 10% of bids accepted. The correlation between this result and the discussions in the preliminary review is particularly noteworthy. The public sector submitted 47% of the total number of applications, representing 76% of their financial value, as compared with 40% and 15% respectively for the private, commercial sector. Public-sector applications thus represented an unexpectedly high financial value and not-for-profit hospitals occupied an intermediate position with 13% of applications, representing 9% of overall financial value.

The data base supplied by the *Rhône-Alpes* ARH reveals the reasons for the rejection of building-renovation projects at this stage. In 50% of cases, rejection was due to non-compliance with the criteria laid down by the Ministry (insufficient conformity with health and safety factors, inadequate evidence of a 50% self-financing capacity). 25% of applications were rejected through insufficient data or inadequate return on investment guarantees. 20% of applications were rejected because the same (or a similar) project had received funding under *Hôpital 2007*.

Applications in the Information Systems category represented less than 5% of the total number of submissions, but 85% of these were successful. The public sector was again the main beneficiary, with a success rate of almost 100%, representing 69% of the total number of applications accepted and 72% of the total value of applications.

[3] Until 2009, the mayor of the City was, by law, the chairperson of the public hospital board (*Conseil d'administration*).

Following extensive consultation, 34 projects were still in the running for final selection at the beginning of this stage. To facilitate selection, a supplementary document was compiled by the ARH, dividing these projects into three categories: (a) for later consideration; (b) falling outside criteria; (c) eligible.

We analysed these 34 remaining projects, according to eight indicators selected from the model drawn up by the MAINH. These concerned two debt-related indicators, two investment-related indicators and four project-efficiency indicators, of which the most significant estimated total gains from the project, against total investment expenditure. Our findings showed that, of the 11 highest-ranking projects according to this indicator, only four corresponded to the projects finally accepted by the ARH. Furthermore, information had been inappropriately recorded regarding return on investment data and projected income levels, which were considered irrelevant for Rehabilitative or Mental Health care, since the T2A system did not apply to these activities. Ultimately, certain decisions were based on incomplete information and others on considerations outwith the criteria initially established.

Exploring further the comparison between the theoretical criteria and actual results through a general typology, we constructed a synthetic indicator based on the aforementioned eight efficiency criteria. Applications were thereby divided into three groups. The first comprises the highest performing applications, the second, those of average efficiency and the third, the least efficient. The typology also differentiates between applications accepted or rejected at this stage.

Table 1 reveals that 50% of successful applications in *Rhône-Alpes* belong to the intermediate group, which is entirely consistent with the 'philosophy' applied in . . . *Provence-Alpes-Côte-d'Azur*! According to that region's rationale, the plan should support projects within hospitals of average size and financial health, but in reality, the same logic objectively, but not explicitly, also prevailed in *Rhône-Alpes*.

The acceptance of two projects from the third group also invites comment. On a methodological level, data provided by both hospitals involved was incomplete, as details for three of the four project-efficiency indicators were missing. The first project concerned a Mental Healthcare public hospital, to which projected income from activity-based payments did not therefore apply, but which was accorded priority because of the infrastructure renovation and managerial improvements it involved. The second concerned the paediatric emergency unit in a private hospital, also involving a merger with another private hospital on a new site.

Table 1
Ranking of projects submitted to the *Rhône-Alpes* ARH.

Groups	No. of projects in group	No. of projects accepted by ARH
(1) High efficiency	11	3
(2) Average efficiency	8	5
(3) Low efficiency	6	2
Totals	25	10

In *Provence-Alpes-Côte-d'Azur*, only 65 applications were received in the building-renovation category in September, of which 22 were rejected at the preliminary review, 18 deferred to the second phase and 25 retained for further consideration. This initial selection was carried out according to 28 criteria, divided into three categories (Medicine and Healthcare, Economics and Finance, Construction Engineering) and a small panel of approximately three people was constituted for each category. The ARH subsequently circulated an explanatory table, showing four main reasons for its rejection decisions: (a) internal restructuring with little impact on provision of care, as outlined in SROS (six cases); (b) supplementary work to an operation already funded (six cases); (c) health and safety improvements which should be undertaken routinely (10 cases, all private sector); (d) level of investment below regional threshold (eight cases).

Out of the 25 building-renovation applications still eligible, only eight were finally selected. Although in several *départements* the private sector submitted more projects than the public sector, the only successful private-sector applications were in the Information Systems category. Moreover, despite ARH encouragement for information-pooling systems, 70% of the funding was devoted to two public hospitals. The eligibility threshold of two million euros for the private sector thus operated as an automatic elimination mechanism. In addition, as in *Rhône-Alpes*, the perception of the private sector as a threat to public hospitals, especially those of medium size and in average financial health, represented a major factor in final decisions.

4. Results and discussion: from procedures to processes

Four main results emerge from the study, each of which gives rise to discussion.

4.1. Time management

The disruption caused by the second Circular, with its new deadline, was appropriated by local actors and allowed hospitals to continue refining their applications from November 2007 until January 2008. Nonetheless, the continuing perception of the ARHs was that the projects submitted to the MAINH would conform closely to the expectations of the Ministry. Ultimately, the projects which emerged from the second selection phase differed significantly from those selected in November. Not only had errors and inconsistencies crept in, but the content had been modified.

These interlocking processes illustrate the classic opposition between the exigencies of close-quarter regulation and those of coordination from a distance [15]. Whereas the latter requires relatively standardised instruments, the former relies on the development of relations based on time, trust and flexibility. In a context where procedures give way to processes, these two modes of regulation may coexist in a mutually antagonistic relationship, even neutralising each other. This tension was reinforced from the outset by the method through which funding was allocated to the regions.

4.2. The private–public issue

In both regions, the public sector emerged as a major beneficiary of the investment plan. The polarisation of *Hôpital 2012* towards the defence of public service values was reinforced by the cooperation dynamic, since this interaction and most of the selection process took place within a professional milieu dominated by such values, rather than market-related considerations. Two other developments reinforced this trend: intensifying competition from powerful private hospital chains and the extension of the T2A system, perceived as a threat.

4.3. Little consideration of health needs

The Ministry's emphasis on financial and quantitative data in the second Circular led the ARHs to focus on individual applications, without relating their decisions to a declared regional policy rationale. Yet, in this configuration, producing the 'right' information becomes a major legitimacy issue, since rationalisation involves revealing the information upon which decisions are based [16]. The procedure adopted led all protagonists to consider that the relevant data was financial and held by the hospitals, resulting in a two-way misunderstanding. Further complexity was engendered by the persistence of 'cross-cutting regulation', represented in the hospital system by direct links between the hospitals and the Ministry, which bypass intermediary bodies and assessment of healthcare needs.

4.4. The questionable efficiency of procedure

The shift from procedure to process also produced positive effects on the quality of selection. The appropriation of the procedure by the ARHs, in cooperation with the hospitals, allowed them to improve the presentation and content of certain projects. Ultimately, what amounted to a second round in the selection process facilitated the selection of approximately 10 highest-ranking applications from those still eligible. In *Provence-Alpes-Côte-d'Azur*, projects deferred to the second phase became eligible for the first, due to the division into operational segments. Others took the opportunity to adjust the level of funding requested to fit actual needs. Despite the policy learning experience, the perception of officials in both ARHs was that their 'political room for manoeuvre' had been limited to deciding between a few applications which all corresponded to major healthcare priorities and that, had the procedure been simpler and quicker, it would have produced the same results.

5. Conclusion

The divergence between anticipated results based on the formal criteria of the plan and the actual results of the selection process carried out by the ARHs is highly significant. It is explicable in terms of the managerial latitude forged by the ARHs in relation to the initial procedure and underpinned by a different, but equally legitimate, economic logic. When efficiency becomes almost synonymous

with the capacity to generate increasing volumes of technical information, data-production may become an end in itself, threatening to undermine the objectives it seeks to pursue. As an instance of NPM in action, the implementation of *Hôpital 2012* highlights the tensions generated by the competition between these different kinds of logic. Through a mixture of deliberate strategy and unplanned responses to such tensions, the ARHs became pivotal actors in the implementation process. Using the time factor as a resource, the ARHs overcame threats to their own legitimacy, making policy choices which deviated from the official efficiency model, but led to increased effectiveness, taking fuller account of local conditions.

The recommendations to be made from a health policy perspective are fourfold.

First, as the policy is decentralized, control by state administration should be exerted *a-posteriori*, rather than *a-priori*, since the efficacy of a multi-level policy depends upon trust between the actors at the different levels.

Second, decentralized policy needs to associate decentralized bodies not only in policy implementation but also in the whole policy-making process.

Third, accountability and reporting are key issues. Our study shows that the more straightforward the procedure, the more accurate its results will be. When economic performance is an imperative, reducing the number of criteria increases procedure efficiency and contributes to clarifying the policy rationale.

Fourth, the time factor is essential for health policy setting, in which evaluation must be continuous and cumulative.

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